



Mackey & Associates, Inc.
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 Charleston, SC 29414-6705
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REQUEST FOR HIPAA CERTIFICATION OF CREDITABLE COVERAGE – NON QUALIFYING EVENT

From: _____ Date: _____ Your Initials: _____
 Company Name

EMPLOYEE INFORMATION:

1. Name _____ 2. Social Security # _____
 Last First MI
 3. Address _____ 4. Phone: () _____
 City State Zip+4
 5. Date of Birth _____ 6. Gender: **Male** **Female** 7. Date of Hire: _____
 8. Is the employee terminating his/her coverage? **YES** **NO**

DEPENDENT INFORMATION FOR THOSE TERMINATING COVERAGE:

9. Spouse Name _____ 10. SSN _____ M / F
 Last First MI
 9a. Child Name _____ 10. SSN _____ M / F
 Last First MI
 9b. Child Name _____ 10. SSN _____ M / F
 Last First MI
 9c. Child Name _____ 10. SSN _____ M / F
 Last First MI
 11. Dependent Address _____ Phone () _____
 (if different) Street (include Apt. #) City State Zip+4
 12. Dependent's DOB Spouse: Child: Child: Child: Child: _____

14. Date of Coverage Termination _____
 15. Reason For Coverage Termination: **Special Enrollment** **Annual Open Enrollment (Renewal Date: _____)**
 Marriage
 Adoption / Placement for Adoption
 Spouse Gains Benefits Thru His/Her Employer
 Birth of A Child
 16. Indicate The Plan Name of All Coverage The Employee and/or Dependent Is Terminating:
 Medical Plan Option: _____
 Dental Plan Option: _____
 Vision Plan Option: _____
 Other Plan Option: _____

Questions or Comments: _____